Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION ANCILLARY SERVICES AFFILIATES LLC
5240 WEST LOOP SOUTH STE 3100
BELLAIRE TX 77401

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LM INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3147-01

MFDR Date Received
MAY 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual is not following the Rules and Regulations set forth of them… but they have fail [sic] to process our claims correctly."

Amount in Dispute: $543.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…We have received the medical dispute filed by Foundation Ancillary Services Affiliates, LLC for services rendered to [injured employee] for the 07/30/2010 date of service. The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged…"

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2010	CPT Codes 95925, 95926 HCPCS Codes A4556, A4557	$543.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 42, Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - 150, Z710 – Documentation does not support level of service billed.
   - D20, B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate

payment allowed.

- D20, B327 – Please provide explanation fo CPT Code 99080 for payment. Identify if report is for DWC069, DWC073, copy of records, or progress report. Attach a copy of this EOB with your resubmission.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the requestor submit a medical bill with the request for medical fee dispute resolution?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(c)(2)(A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Review of the submitted documentation finds that the requestor did not submit copies of medical bills. The Division concludes that the requestor has not met the requirements of 133.307(c)(2)(A).
2. Review of the submitted documentation finds that the request for reimbursement is not supported and payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.